FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031385

Facility Name: SKOKIE MEADOWS N CENTER #1

Address: 9615 N. KNOX AVE. (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-4161 **Fax #** (847) 329-8633

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 03/23/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	113	Skilled (SNF)	113	41,358	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,358	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,001	3,001	8
9	SNF/PED					9
10	ICF	29,292	2,058	3,845	35,195	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,292	2,058	6,846	38,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.35%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/23/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/23/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 3,001

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	241,738	8,744	8,273	258,755		258,755		258,755			1
2	Food Purchase		138,944		138,944	(19,032)	119,912	(81)	119,831			2
3	Housekeeping	130,497	15,711		146,208		146,208		146,208			3
4	Laundry	68,720	17,016		85,736		85,736		85,736			4
5	Heat and Other Utilities			97,179	97,179		97,179	128	97,307			5
6	Maintenance		9,891	36,741	46,632		46,632	950	47,582			6
7	Other (specify):*			13,647	13,647		13,647		13,647			7
8	**TOTAL General Services**	440,955	190,306	155,840	787,101	(19,032)	768,069	997	769,066			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,699,987	48,540	59,073	1,807,600		1,807,600		1,807,600			10
10a	Therapy	19,634		1,210	20,844		20,844		20,844			10a
11	Activities	87,497	9,258		96,755		96,755		96,755			11
12	Social Services	117,474		3,815	121,289		121,289		121,289			12
13	Nurse Aide Training											13
14	Program Transportation			938	938		938		938			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,924,592	57,798	66,236	2,048,626		2,048,626		2,048,626			16
	C. General Administration											
17	Administrative	95,072		414,520	509,592		509,592	(391,798)	117,794			17
18	Directors Fees											18
19	Professional Services			93,817	93,817		93,817	4,911	98,728			19
20	Dues, Fees, Subscriptions & Promotions			50,703	50,703		50,703	(42,150)	8,553			20
21	Clerical & General Office Expenses	131,963	8,436	231,056	371,455		371,455	(116,637)	254,818			21
22	Employee Benefits & Payroll Taxes			457,681	457,681	19,032	476,713		476,713			22
23	Inservice Training & Education			4,401	4,401		4,401		4,401			23
24	Travel and Seminar			3,126	3,126		3,126	(3,126)				24
25	Other Admin. Staff Transportation			19,919	19,919		19,919		19,919			25
26	Insurance-Prop.Liab.Malpractice			147,266	147,266		147,266		147,266			26
27	Other (specify):*							13,319	13,319			27
28	**TOTAL General Administration**	227,035	8,436	1,422,489	1,657,960	19,032	1,676,992	(535,481)	1,141,511			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,592,582	256,540	1,644,565	4,493,687		4,493,687	(534,484)	3,959,203			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SKOKIE MEADOWS N CENTER #1 **#0031385** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,273	
	REPAIRS & MAINTENANCE		0	
			0	8,273
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		47,938	
	ELECTRICITY		26,771	
	WATER		18,017	
	CABLE TV - LOBBY		4,453	
			0	97,179
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		13,405	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		2,223	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,599	
	ELEVATOR MAINTENANCE & REPAIR		4,366	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,184	
	FIRE SERVICE		2,964	
			0	
			0	
			0	36,741
7	**OTHER**			
	SCAVENGER		13,647	
	SECURITY SERVICE		0	13,647
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		11,705	
	PURCHASED SERVICES		28,598	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	1,392	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	3,000	
	PSYCHIATRIC	XVIII B __-2	6,000	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		4,250	
			0	59,073
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	1,210	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,210
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,815	
			0	3,815
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 **#0031385** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		938	938
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	414,520	414,520
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,551	
	ADMINISTRATIVE CONSULTANTS	XIX C	5,000	
	PROFESSIONAL FEES	XIX C	73,266	
			0	93,817
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	26,643	
	EMPLOYEE WANT ADS	XIX F	1,562	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,726	
	LICENSES & PERMITS	XIX F	1,265	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	13,348	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,159	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	50,703
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,741	
	EQUIPMENT REPAIR & MAINTENANCE		586	
	OUTSIDE CLERICAL SERVICES		215,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,229	
	MESSENGER SERVICE		0	
			0	231,056

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	199,358	
	UNEMPLOYMENT COMPENSATION	XIX D	21,034	
	WORKERS COMPENSATION INSURANCI	XIX D	40,971	
	HOSPITALIZATION INSURANCE	XIX D	164,002	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,614	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,187	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	26,515	
	CHICAGO HEAD TAX	XIX D	0	457,681
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,401	4,401
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	3,126	
			0	
			0	3,126
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		19,919	19,919
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		147,266	147,266
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,644,565

SKOKIE MEADOWS N CENTER #1
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	138,944	PATIENT MEALS	114588
LESS SALES TAX	(81)	ADD EMPLOYEE MEALS	18300
NET FOOD	138,863	TOTAL MEALS/YEAR	132888
TOTAL PATIENT CENSUS	38,196	NET FOOD	138863
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	132888
TOTAL PATIENT MEALS	114588	COST PER MEAL	1.04
		TIME EMPLOYEE MEALS	18300
ADD # EMPLOYEE MEALS/DAY	50		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	19032
TOTAL EMPLOYEE MEALS	18300		

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 #0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			42,892	42,892		42,892	98,631	141,523			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,124	47,124		47,124	121,414	168,538			32
33	Real Estate Taxes			243,411	243,411		243,411		243,411			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)				34
35	Rent-Equipment & Vehicles			53,048	53,048		53,048	3,922	56,970			35
36	Other (specify):*											36
37	**TOTAL Ownership**			915,223	915,223		915,223	(304,781)	610,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,489	301,357	488,846		488,846		488,846			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,037	62,037		62,037		62,037			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		187,489	363,394	550,883		550,883		550,883			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,592,582	444,029	2,923,182	5,959,793		5,959,793	(839,265)	5,120,528			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,511	30		9
10	Interest and Other Investment Income	(353,243)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(81)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,159)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(26,643)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(13,348)	20		28
29	Other-Attach Schedule	(3,917)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (391,880)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(447,385)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (447,385)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (839,265)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SKOKIE MEADOWS N CENTER #1

ID# 0031385

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 950	6	1
2	BANK CHARGE	(1,741)	21	2
3	NON ALLOWABLE TRAVEL	(3,126)	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,917)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(81)	0	0	0	0	0	0	0	0	0	0	(81)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	128	0	0	0	0	0	0	0	0	0	128	5
6	Maintenance	950	0	0	0	0	0	0	0	0	0	0	950	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	869	128	0	0	0	0	0	0	0	0	0	997	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(391,798)	0	0	0	0	0	0	0	0	0	(391,798)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,286	2,625	0	0	0	0	0	0	0	0	4,911	19
20	Fees, Subscriptions & Promotions	(42,150)	0	0	0	0	0	0	0	0	0	0	(42,150)	20
21	Clerical & General Office Expenses	(1,741)	(114,896)	0	0	0	0	0	0	0	0	0	(116,637)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,126)	0	0	0	0	0	0	0	0	0	0	(3,126)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	13,319	0	0	0	0	0	0	0	0	0	13,319	27
28	**TOTAL General Administration**	(47,017)	(491,089)	2,625	0	0	0	0	0	0	0	0	(535,481)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,148)	(490,961)	2,625	0	0	0	0	0	0	0	0	(534,484)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,511	0	91,120	0	0	0	0	0	0	0	0	98,631	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(353,243)	0	474,657	0	0	0	0	0	0	0	0	121,414	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	3,922	0	0	0	0	0	0	0	0	0	3,922	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(345,732)	3,922	37,029	0	0	0	0	0	0	0	0	(304,781)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(391,880)	(487,039)	39,654	0	0	0	0	0	0	0	0	(839,265)	45

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS I	SKOKIE	PREMIER		BOOKKEEPING
		SKOKIE MEADOWS II	SKOKIE	MANAGEMENT	SKOKIE	MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 414,520	PREMIER MANAGEMENT		$	$ (414,520)	1
2	V	21	OUTSIDE CLERICAL SVC	191,500	PREMIER MANAGEMENT			(191,500)	2
3	V	21	OUTSIDE SERVICES	24,000	1139 BEVERLY			(24,000)	3
4	V	5	UTILITIES		PREMIER MANAGEMENT		128	128	4
5	V	17	OFFICER SALARIES		PREMIER MANAGEMENT		22,722	22,722	5
6	V	19	PROFESSIONAL FEES		PREMIER MANAGEMENT		2,286	2,286	6
7	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		15,300	15,300	7
8	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		6,375	6,375	8
9	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		8,192	8,192	9
10	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT		23,039	23,039	10
11	V	21	CLERICAL		PREMIER MANAGEMENT		47,698	47,698	11
12	V	27	PAYR. TAXES/HEALTH INS		PREMIER MANAGEMENT		13,319	13,319	12
13	V	35	OFFICE RENTAL		PREMIER MANAGEMENT		3,922	3,922	13
14	Total			$ 630,020			$ 142,981	$ * (487,039)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 528,748	M O SKOKIE MEADOWS		$	$ (528,748)	15
16	V	30	DEPRECIATION				91,120	91,120	16
17	V	32	INTEREST				474,657	474,657	17
18	V	19	ACCOUNTING FEES				2,625	2,625	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 528,748			$ 568,402	$ * 39,654	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	ADMINISTRATIV	100.00	Momence-$24,108	See Attached		Salary	$ 22,722	17-7	1
2			BANKING		Skokie 2-$23,417						2
3			FINANCE		Cal Homes-$89,753						3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,722		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 679-7733
Fax Number: (847) 679-7736

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	268,959	7	$ 900	$	38,196	$ 128	1
2	17	OFFICER SALARIES	PER RESIDENT DAY	268,959	7	160,000	160,000	38,196	22,722	2
3	19	PROFESSIONAL FEES	PER RESIDENT DAY	268,959	7	16,098		38,196	2,286	3
4	21	CLERICAL SALARIES	DIRECT	6	3	45,900	45,900	2	15,300	4
5	21	CLERICAL SALARIES	DIRECT	4	3	25,500	25,500	1	6,375	5
6	21	CLERICAL SALARIES	DIRECT	10	4	40,962	40,962	2	8,192	6
7	21	CLERICAL SALARIES	DIRECT	10	3	115,196	115,196	2	23,039	7
8	21	CLERICAL	PER RESIDENT DAY	268,959	7	335,870	239,921	38,196	47,698	8
9	27	PAYR. TAXES/HEALTH INS	PER RESIDENT DAY	268,959	7	93,784		38,196	13,319	9
10	35	OFFICE RENTAL	PER RESIDENT DAY	268,959	7	27,619		38,196	3,922	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 861,829	$ 627,479		$ 142,981	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: M O SKOKIE MEADOWS NURSING
Street Address: 9615 N KNOX
City / State / Zip Code: SKOKIE,IL 60076
Phone Number: (847)679-7733
Fax Number: (847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 91,120	$	1	$ 91,120	1
2	32	INTEREST	DIRECT	1	1	474,657		1	474,657	2
3	19	PROFESSIONAL FEES-ACCT.	DIRECT	1	1	2,625		1	2,625	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 568,402	$		$ 568,402	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	CAMBRIDGE		X	MORTGAGE	$44,062.00	8/16/01	6,822,050	6,660,344	8/16/36	0.0710	474,657	2
3												3
4												4
5												5
	Working Capital											
6	1ST EQUITY		X	WORKING CAPITAL	INT ONLY			646,327			35,986	6
7	SHAREHOLDER LOAN	X						396,138		0.0400	11,138	7
8												8
9	TOTAL Facility Related				$44,062.00		$ 6,822,050	$ 7,702,809			$ 521,781	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,822,050	$ 7,702,809			$ 521,781	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 159,393	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 201,402	2
3. Under or (over) accrual (line 2 minus line 1).		$ 42,009	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 201,402	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 243,411	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	171,674	8
	2000	176,544	9
	2001	156,179	10
	2002	159,393	11
	2003	201,402	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS N CENTER #1 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031385

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-042-0000	NURSING HOME	$ 201,402.09	$ 201,402.09
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 201,402.09	$ 201,402.09

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING		1990	$ 347,575	1
2					2
3	TOTALS			$ 347,575	3

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		1990		$ 1,968,925	$ 62,506	31.5	$ 62,506	$	$ 836,036	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENT			1987	4,888	155	20	155		3,837	9
10	IMPROVEMENT			1988	3,196	101	31.5	101		1,691	10
11	IMPROVEMENT			1990	29,530	937	31.5	937		13,170	11
12	IMPROVEMENT			1991	20,962	665	31.5	665		9,007	12
13	IMPROVEMENT			1992	18,635	593	31.5	593		7,366	13
14	IMPROVEMENT			1993	50,200	1,594	31.5	1,594		18,921	14
15	IMPROVEMENT			1993	8,052	206	39	206		2,343	15
16	IMPROVEMENT			1994	71,864	1,843	39	1,843		19,467	16
17	FIRE DAMPERS			1995	4,980	128	39	128		1,264	17
18	NURSE STATION REMODELING			1995	70,129	1,798	39	1,798		17,007	18
19	CONCRETE WORK, PATIO, RAMPS			1995	21,904	1,460	39	1,460		14,053	19
20	RESIDENT ROOM REMODELING			1996	25,459	653	15	653		5,632	20
21	ROOF			1996	1,200	31	39	31		279	21
22	REHABBING 1ST FLOOR CORRIDOR LOWER WALLS			1997	14,497	372	39	372		2,806	22
23	DOOR			1997	1,455	37	39	37		294	23
24	ELEVATOR RENOVATION			1997	14,791	379	39	379		2,700	24
25	FIRE DAMPERS			1998	7,282	187	39	187		1,285	25
26	EXHAUST FANS			1998	4,135	106	39	106		705	26
27	FIRE DAMPERS & 21 GRILLS			1998	22,408	575	39	575		3,806	27
28	ACCESS PANELS & FIRE DAMPERS			1998	2,720	70	39	70		429	28
29	TILING			1999	14,344	368	39	368		2,039	29
30	KIL-BAR			1999	3,587	92	39	92		510	30
31	WALL HEATERS			1999	6,392	164	39	164		909	31
32	DOOR			1999	1,190	30	39	30		167	32
33	WINDOW REPLACEMENT			1999	61,410	1,575	39	1,575		8,728	33
34	SHOWER ROOM TILING			1999	9,206	236	39	236		1,308	34
35	GENERATOR			2000	62,880	2,287	27.5	2,287		10,291	35
36	TILING			2000	6,052	220	27.5	220		990	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALL COVERING	2000	$ 33,819	$ 3,020	7	$ 4,831	$ 1,811	$ 25,450	37
38	AWNING	2001	2,951	107	27.5	107		379	38
39	CORNICES	2001	1,741	63	27.5	63		223	39
40	ROOF	2001	50,988	1,854	27.5	1,854		6,566	40
41	DOOR	2001	2,160	79	27.5	79		280	41
42	ELEVATOR DOOR	2001	10,450	380	27.5	380		1,346	42
43	TWO DECK ROOFS	2001	12,100	440	27.5	440		1,558	43
44	5 TON CONDENSING UNIT	2001	2,854	104	27.5	104		368	44
45	WALLPAPERING, PAINTING	2002	60,000	8,064	5	12,000	3,936	30,000	45
46	FLORIDA SMOKING ROOM	2002	27,967	1,017	27.5	1,017		2,585	46
47	DUCTLESS SPLIT ROOM	2002	12,377	450	27.5	450		1,144	47
48	VALVE	2002	2,160	78	27.5	78		199	48
49	SIGN	2002	2,450	163	15	163		408	49
50	SHEET LEAD SHOWER LINER PANS	2002	5,471	199	27.5	199		506	50
51	SHOWER BASIN TILING	2002	15,498	564	27.5	564		1,433	51
52	PAVING PARKING LOT	2002	12,495	833	15	833		2,082	52
53	CONCRETE FOOTINGS, WALLS, STEPS,	2002	29,975	1,090	27.5	1,090		2,770	53
54	COOLER DOOR	2002	3,772	137	27.5	137		348	54
55	SIGN	2002	4,590	306	15	306		765	55
56	TUCKPOINTING	2002	24,600	894	27.5	894		2,273	56
57	4 TON CONDENSING UNIT	2002	4,800	175	27.5	175		444	57
58	VCT,COVE BASE	2003	4,639	168	27.5	168		259	58
59	ELEVATOR SAFETY EDGE	2003	1,575	58	27.5	58		89	59
60	NURSE CALL SYSTEM	2003	4,596	167	27.5	167		258	60
61	CARPET	2003	1,752	392	5	154	(238)	504	61
62	BLINDS	2003	2,648	419	5	530	111	1,060	62
63	CUBICLE CURTAINS, PAINTING,WALLPAPER	2003	5,805	933	5	1,161	228	2,322	63
64	INSTALL TRENCH DRAIN	2004	8,120	406	15	406		406	64
65	LIGHT FIXTURES	2004	9,188	181	27.5	181		181	65
66	REHAB ELEVATOR	2004	29,846	588	27.5	588		588	66
67	10 TON COOLING UNITS	2004	16,983	334	27.5	334		334	67
68	TILING, COVE BASE	2004	64,000	97	27.5	97		97	68
69	CEILINGS & LIGHTING	2004	51,173	78	27.5	78		78	69
70	TOTAL (lines 4 thru 69)		$ 3,055,816	$ 103,206		$ 109,054	$ 5,848	$ 1,074,343	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 321,299	$ 17,034	$ 31,321	$ 14,287	10	$ 220,096	71
72	Current Year Purchases	22,953	13,772	1,148	(12,624)	10	1,148	72
73	Fully Depreciated Assets	439,377					439,377	73
74								74
75	TOTALS	$ 783,629	$ 30,806	$ 32,469	$ 1,663		$ 660,621	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,187,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 134,012	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 141,523	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,511	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,734,964	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 528,748			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 528,748 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 35,163 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	2002 ECOCO VAN E350	$ 555.00	$ 6,680	17
18	DON	2001 ILDS ALERO	472.00	5,665	18
19	ADMINISTRATOR	2002 CADILLAC	927.00	5,540	19
20					20
21	TOTAL		$ #######	$ 17,885	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 99,448	$		$ 99,448	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			36,163			36,163	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			147,665			147,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				187,489		187,489	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8				18,081			18,081	13
14	TOTAL			$		$ 301,357	$ 187,489		$ 488,846	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,466,405	$	1
2	Cash-Patient Deposits	3,457		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,111,330		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,305		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Loans, Adv Wage	3,500		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,661,997	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	419,519		15
16	Equipment, at Historical Cost	147,302		16
17	Accumulated Depreciation (book methods)	(138,922)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Due From Related Parties	6,118,958		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,546,857	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,208,854	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,783	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,042,465		29
30	Accrued Salaries Payable	121,834		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	201,402		32
33	Accrued Interest Payable	3,275		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,578,759	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,006,206		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,006,206	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,584,965	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,623,889	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,208,854	$	48

*(See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,905,498	1
2	Restatements (describe):		2
3	SKOKIE 2 ELIMINATION ENTRY &		3
4	POST CLOSING ENTRIES	(2,072,020)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,833,478	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(430,941)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PAID IN CAPITAL	2,221,352	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,790,411	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,623,889	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,928,364	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,928,364	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	245,408	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 245,408	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	353,243	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 353,243	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,837	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,837	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,528,852	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	787,101	31
32	Health Care	2,048,626	32
33	General Administration	1,657,960	33
	B. Capital Expense		
34	Ownership	915,223	34
	C. Ancillary Expense		
35	Special Cost Centers	488,846	35
36	Provider Participation Fee	62,037	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,959,793	40
41	**Income before Income Taxes (line 30 minus line 40)****	(430,941)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (430,941)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
CONSOLIDATED TAX RETURN WITH SKOKIE 2 IS DONE

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	8,030	8,531	$ 264,939	$ 31.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,595	32,524	829,974	25.52	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	60,366	65,455	605,074	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,636	1,754	19,634	11.19	8
9	Activity Director					9
10	Activity Assistants	7,404	8,140	87,497	10.75	10
11	Social Service Workers	6,976	7,552	117,474	15.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,427	21,840	241,738	11.07	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,709	15,070	130,497	8.66	18
19	Laundry	7,445	8,247	68,720	8.33	19
20	Administrator	3,056	3,208	95,072	29.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,242	9,314	131,963	14.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,886	181,635	$ 2,592,582 *	$ 14.27	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	207	$ 8,273	1-3	35
36	Medical Director	10	1,200	9-3	36
37	Medical Records Consultant	136	4,128	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	9	1,392	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	153	3,815	12-3	45
46	Other(specify) REHABILITATION	30	1,210	10a-3	46
47	PHYSICIANS & PSYCHIATRIC	45	9,000	10-3	47
48	PROGRAM CONSULTANT	34	4,250	10-3	48
49	TOTAL (lines 35 - 48)	624	$ 33,268		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LARRY TORF	ADMIN		$ 95,072
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,072

B. Administrative - Other

Description	Amount
PREMIER MANAGEMENT - MANAGEMENT FEES	$ 414,520
TOTAL (agree to Schedule V, line 17, col. 3)	$ 414,520
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		93,817
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 93,817

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 40,971
Unemployment Compensation Insurance		21,034
FICA Taxes		199,358
Employee Health Insurance		164,002
Employee Meals		19,032
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		4,614
EMPLOYEE PHYSICAL EXAMS		1,187
PENSION/PROFIT SHARING PLANS		26,515
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 476,713

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,562
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	39,991
TRUST/FRANCHISE/CONTRIB/ETC	2,159
LICENSES & PERMITS	1,265
DUES & SUBSCRIPTIONS	5,726
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(2,159)
Less: Public Relations Expense	(0)
Non-allowable advertising	(26,643)
Yellow page advertising	(13,348)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,553

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,126
NON ALLOW TRAVEL	(3,126)
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIC	2001	$ 4,429	3 YRS	$ 739	$ 1,477	$ 1,477	$ 736	$	$	$	$	$
2	PAINTING/DECORATIC	2002	642	3 YRS		107	214	214	107				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,071		$ 739	$ 1,584	$ 1,691	$ 950	$ 107	$	$	$	$

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $6441**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **62,037**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,032** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees